Arizona Health Care Cost Containment System
Department of Economic Security

Comprehensive Medical and Dental Program

Report for Contract Year 2004

External Quality Review Organization Annual Report

Submitted by
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EQRO Annual Report
Contract Year 2004
Comprehensive Medical and Dental Program
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EXECUTIVE SUMMARY

The Comprehensive Medical and Dental Program (CMDP) is a state operated managed health care plan for children and adolescents (birth to 21 years of age) enrolled in foster care. CMDP is operated by the Arizona Department of Economic Security (DES) and receives funding from the Arizona Health Care Cost Containment System (AHCCCS) for those foster children who qualify for Medicaid coverage. CMDP has an intergovernmental contract with AHCCCS, which defines the relationship between the two state agencies, including the coverage parameters as well as all of the requirements related to quality of, and access to, care. CMDP is viewed by AHCCCS administration to be in the same category as any of the AHCCCS contracted acute care health plans and is held to the same performance standards.

For purposes of compliance with the Balanced Budget Act (BBA) of 1997, AHCCCS contracted with an External Quality Review Organization (EQRO) to review the quality monitoring and other oversight activities performed by AHCCCS during contract year 2004 (January 2004 through December 31, 2004), to assess the strengths and weaknesses of the contractor's performance.

Overall, the external quality review determined that AHCCCS had a well developed process for monitoring CMDP's compliance with federal and state requirements related to the quality and timeliness of, and access to, care and service provided to members enrolled with CMDP, as well as ensuring necessary interventions were implemented to remedy areas of deficiency, as required in 42 CFR 438.200. AHCCCS accomplished this oversight through the following actions.

- Establishing a set of performance measures and standards by which it was able to assess CMDP's performance related to the provision of quality care to its members
- Instituting quality control and study validation procedures to ensure consistent and accurate data are used in analyzing performance measures and conducting Performance Improvement Projects (PIPs)
- Designing and conducting, in accordance with CMS protocols, an AHCCCS-mandated PIP, to improve CMDP's immunization rates for two year old members
- Assessing CMDP's compliance with federal and state requirements through a document review and approval process carried out throughout the contract year, and an on-site operational and financial review, using a standardized tool and protocol that incorporated all seven of the compliance review activities included in the CMS protocol for determining compliance with Medicaid managed care regulations
- Approving and monitoring the effectiveness of CMDP's corrective action plans to address deficiencies and improve performance

Regarding CMDP's performance, an assessment of the performance measures and PIP results indicates that CMDP was continuing to improve its performance related to the

provision of quality care to its members and, in some instances, met or exceeded the AHCCCS minimum performance levels. However, the draft results from the operational and financial review indicate the need for CMDP to continue to work on achieving full compliance with a number of the operational compliance standards. Over the coming year, it will be important for AHCCCS to continue its success to both monitor the effectiveness of the CMDP proposed interventions, as well as work collaboratively with CMDP to guide it in efforts aimed at improving performance.

I. INTRODUCTION

The Comprehensive Medical and Dental Program (CMDP) is the state operated health care plan for children and adolescents (birth to 21 years of age) who are enrolled in foster care. CMDP is operated by the Arizona Department of Economic Security (DES) and receives funding from the Arizona Health Care Cost Containment System (AHCCCS) for those foster children who qualify for Medicaid coverage. Children are eligible for enrollment in CMDP when placed in foster care by the DES Division of Child Protective Services, the Arizona Department of Juvenile Corrections, or the Administrative Office of the Court/Juvenile Probation Office.

CMDP has an intergovernmental contract with AHCCCS defining the relationship between the two state agencies, including the coverage benefits as well as all of the requirements related to quality of care and access to care. CMDP is considered by AHCCCS administration to be in the same category as the AHCCCS contracted acute care health plans and is held to the same performance standards. Benefits for those members of CMDP eligible for Medicaid are the same as those members in acute care plans. CMDP has a preferred provider network of physicians from which the foster care family is encouraged to choose a primary care provider.

Because of the Balanced Budget Act (BBA) of 1997, AHCCCS has modified its contract with DES/CMDP to include those elements that are required to monitor and measure quality of care. These include Performance Improvement Projects (PIPs) and Performance Measures. The BBA of 1997 requires an annual review of compliance with federal and state law regarding managed care systems. The requirement for an annual External Quality Review Organization (EQRO) report also is in the BBA of 1997. AHCCCS has contracted with HCE QualityQuest to write the EQRO Annual Report for CMDP for contract year 2004.

The review period for this EQRO Annual Report is from January 1, 2004 through December 31, 2004. During this timeframe, the AHCCCS eligible members enrolled in CMDP grew about 20%, from 7,212 in January of 2004 to 8,603 in December of 2004. Of these children, approximately 7% are less than 1 year of age, 67% are ages 1 to 13, and 26% are ages 14 to 20. The performance measures and Performance Improvement Projects are calculated using encounter data, which are sent to AHCCCS from CMDP, and are only for those members eligible for Medicaid and enrolled with AHCCCS.

II. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE MEASURES

A. Objectives

AHCCCS has adopted a set of performance measures[1] that are applied uniformly to all of its publicly and privately operated acute care health plans, including CMDP. As described in *AHCCCS Quality Assessment and Performance Improvement Strategy*, these performance measures are used by AHCCCS as indicators of service utilization and the quality of care provided to CMDP members. Since foster care children are automatically enrolled in CMDP, these standardized performance measures are not used as a means to influence choice of health plan but for the purpose of improving the delivery of quality care by CMDP. By analyzing the trends over time in relation to minimum performance standards, AHCCCS and CMDP are able to identify areas for improvement and implement interventions to increase effectiveness of care, access and/or availability of care, and appropriate use of services. They also are able to compare the overall performance of CMDP with that of other AHCCCS contracted acute care health plans as well as with commercial health plan national averages. This is one way to assure the members and the taxpayers that foster children are receiving the same quality heath care as the rest of the Medicaid population in Arizona and are being "mainstreamed" into the same delivery system.

1. Performance Measure Requirements

For this EQRO Annual Report review period, AHCCCS set forth its requirements related to performance measures for CMDP in the following documents.

- *AHCCCS and Department of Economic Security (DES), CMDP Contract*, Section D (13): Performance Standards (10/1/03 – 12/31/04)
- *AHCCCS Medical Policy Manual*, Policy 970 Performance Indicators

Per these documents, CMDP was required to improve its performance scores for all AHCCCS established performance measures. Additionally, as part of its Quality Management Improvement Program, CMDP was to report its results using these performance measures and provide documentation of its planned activities and interventions to meet or exceed the standards established by AHCCCS for each measure.

To be able to systematically evaluate CMDP's performance and to ensure that appropriate care was being provided to CMDP members, AHCCCS established standards for each of its mandatory performance measures using the following three definitions of levels of performance.

- Minimum Performance Standard: the minimally acceptable level of performance that CMDP was required to meet.

- Contract Year Goal: the reachable standard set for the particular contract year. If CMDP met the minimum performance standard, then it was expected to strive to meet the contract year goal.
- Benchmark: the ultimate standard that CMDP was expected to reach or exceed and maintain. The benchmarks were based on the Healthy People 2000 or 2010 goals for health promotion and disease prevention as determined by the United States Department of Health and Human Services.

For CMDP, AHCCCS tailored the list of mandated performance measures for acute care health plans to reflect the uniqueness of the CMDP population (e.g., limited to children and adolescents). Thus, a performance measure such as breast cancer screening for women ages 52 through 64 years was not included as a required CMDP performance measure. In CMDP's 2004 contract AHCCCS established standards for the following performance measures.

- Pediatric Immunizations (two-year old children with 8 separate measures)
- Children's Access to Primary Care Practitioners (ages 1 through 20 years)
- Dental Visits (ages 3 through 20 years)
- Well-Child Visits (ages birth through 15 months)
- Well-Child Visits (ages 3 through 6 years)
- Adolescent Well-Care Visits (ages 11 through 20 years)
- EPSDT Participation

2. Monitoring and Compliance of Performance Measures

In monitoring performance measures, AHCCCS adopted the rotation schedule used by the National Committee for Quality Assurance (NCQA). Performance measures are now alternated on a biennial basis, allowing the acute care health plans an intervention year between most measures, and providing adequate time to for them to put in place activities for improving specific performance measure rates. During the review period, AHCCCS produced the following two acute care health plan performance measure reports that included results for CMDP.

- *AHCCCS Quality Management Performance Measures for Acute-Care Contractors* (measurement period ending September 30, 2003). This report, which was issued December 2004, included results of CMDP performance for children's access to Primary Care Practitioners.
- *AHCCCS Biennial Report of Immunization Completion Rates by 24 Months of Age*. This report was issued on March 2004 for contract year ending September 30, 2003.

Additionally, AHCCCS released just prior to the EQRO Annual Report review period, the December 2003, *AHCCCS Acute Care Performance Indicators Results and Analysis* (measurement period ending September 30, 2002). This report included results of CMDP performance for the following measures.

- Children's Access to Primary Care Practitioners
- Well-Child Visits
- Adolescent Well-Care Visits
- Annual Dental Visits

AHCCCS posted these reports on the AHCCCS Web site, with the expectation that publicly posting the individual health plan performance measure rates will be viewed as an incentive by the health plans to improve their performance.

As set forth in the AHCCCS contract with CMDP, if CMDP did not demonstrate and sustain improvement toward meeting these performance standards, including meeting the minimum performance standards, CMDP would be required to submit a corrective action plan (see discussion under Assessment of Strengths and Weakness). These required corrective action plans had to be approved by AHCCCS. Additionally, AHCCCS, if necessary, could conduct one or more follow-up on-site reviews to verify compliance with the corrective action plan. Failure to achieve improvements could result in monetary sanctions against CMDP.

B. Description of Data Collection Methodology

The AHCCCS methodology used for its mandated performance measures was modeled after the Health Plan Employer Data and Information Set (HEDIS®), 2004, which is developed and maintained by NCQA. The HEDIS® measures are nationally recognized by health care experts as an acceptable tool for measuring health care performance by managed care organizations. These measures also offered the added benefit of having a specific set of Medicaid HEDIS® measures designed to reflect the unique characteristics of the Medicaid population.

AHCCCS measured the same health care parameters as set forth in the HEDIS® methodology but made minor modifications in the denominator to better coordinate with the contract cycles and membership variables of Arizona's Medicaid program. AHCCCS employed two different data collection methodologies for its mandated performance measures, one for the immunization performance measure and a second for the other mandated performance measures.

1. Immunization Performance Measures

For the immunization measures, AHCCCS employed a hybrid data collection methodology which used administrative data together with medical record review, as needed, for the numerator. Based on a representative sample of CMDP members, AHCCCS first queried available administrative data (i.e., immunization data) in the Arizona State Immunization Information System (ASIIS), which is the statewide mandated childhood immunization registry. For any member of the sample who had incomplete or missing immunization records, CMDP was required to provide the additional immunization data in accordance with HEDIS® methodology by either reviewing medical records or using administrative (claims) information. A more detailed

description of the data collection methodology and analysis has been included in Section III on Performance Improvement Projects.

2. Other Performance Measures (Non-Immunization Related)

For each of the non-immunization related performance measures, AHCCCS data collection methodology and measurement criteria were described in a document entitled *AHCCCS Methodology and Technical Specifications for Adult and Pediatric Performance Indicators (Measurement Period from 10/1/02 through 9/30/03).* For each measure, a description was provided of the population, sample frame (i.e., selection criteria), population stratification, population exclusions, data sources, data collection, data validation, denominator, numerator, comparative analysis, deviations from HEDIS® methodology, report format, recipient subsystem requirements, encounter subsystem requirements, service selection criteria, and service exclusionary criteria.

AHCCCS used administrative data to calculate both the denominator and the numerator of each performance measure. The necessary administrative data were extracted from the AHCCCS Prepaid Medical Management Information System (PMMIS) recipient subsystem and encounter subsystem, following the criteria set forth in the *AHCCCS Methodology and Technical Specifications for Adult and Pediatric Performance Indicators*. No additional outside data were collected to produce these performance measures.

C. Validation of Measure

AHCCCS assumed responsibility for validating its mandated performance measures in terms of specifications for the eligible population for the measure, data collection methodology, sampling methodology (when used), denominator calculation, numerator calculation, and calculated and reported rates. AHCCCS developed the following written procedures to ensure the collection of valid and reliable data for performance measures and Performance Improvement Projects.

- *Acute Care Performance Measure and Performance Improvement Project (PIP) Quality Control Processes,* which includes validation of sample frame and, if applicable, quality control of selected member files from the acute care health plans.
- *Study Validation Process,* which includes conducting a double-blind audit of all the records of members selected for the validation, using an independent third party to analyze the results. This independent review also may be conducted by AHCCCS staff; use of an external agent is optional.

Through its data validation process, AHCCCS was able to ensure that all encounter data was for the appropriate service records and met the performance measures' service selection criteria; the process also ensured that selected recipients met the proper enrollment criteria.

In addition, AHCCCS has separate program-wide validation processes which are used to validate the encounter and the recipient subsystem data files. At the time of this report, however, CMDP was not included in the AHCCCS encounter data validation process.

D. Assessment of Strengths and Weakness

1. Performance Measure Results

To assess the strengths and weaknesses of CMDP as it related to the AHCCCS mandated performance measures, the results for CMDP contained in AHCCCS performance measure reports for 2001, 2003 and 2004 were compiled as follows.

- Children's Access to Primary Care Practitioners (Table 1 and Figure 1)
- Immunizations Completion Rates by 24 Months of Age (Table 2 and Figure 2)
- Well-Child Visits (Table 3 and Figure 3)
- Dental Visits (Table 4 and Figure 4)

The AHCCCS health plan averages, as well as the NCQA Medicaid HEDIS® health plan averages, were included in the tables and figures for comparison purposes.

Table 1: CMDP Performance Measure for Children's Access to Primary Care Practitioners Compared to Other Rates and Benchmarks*						
Children's Access to Primary Care	Previous Performance	Recent Performance	Minimum Performance Level	CY 2004 Goal	AHCCCS Health Plan Average	Benchmark
	CY 2002	CY 2003			CY 2003	
0-20 years	83.7%	79.1%	77%	80%	75.7%	97%

*NCQA 2003 Medicaid HEDIS® only measures children's access to primary care practitioners for children ages 1-11, and no comparable national Medicaid average is available.

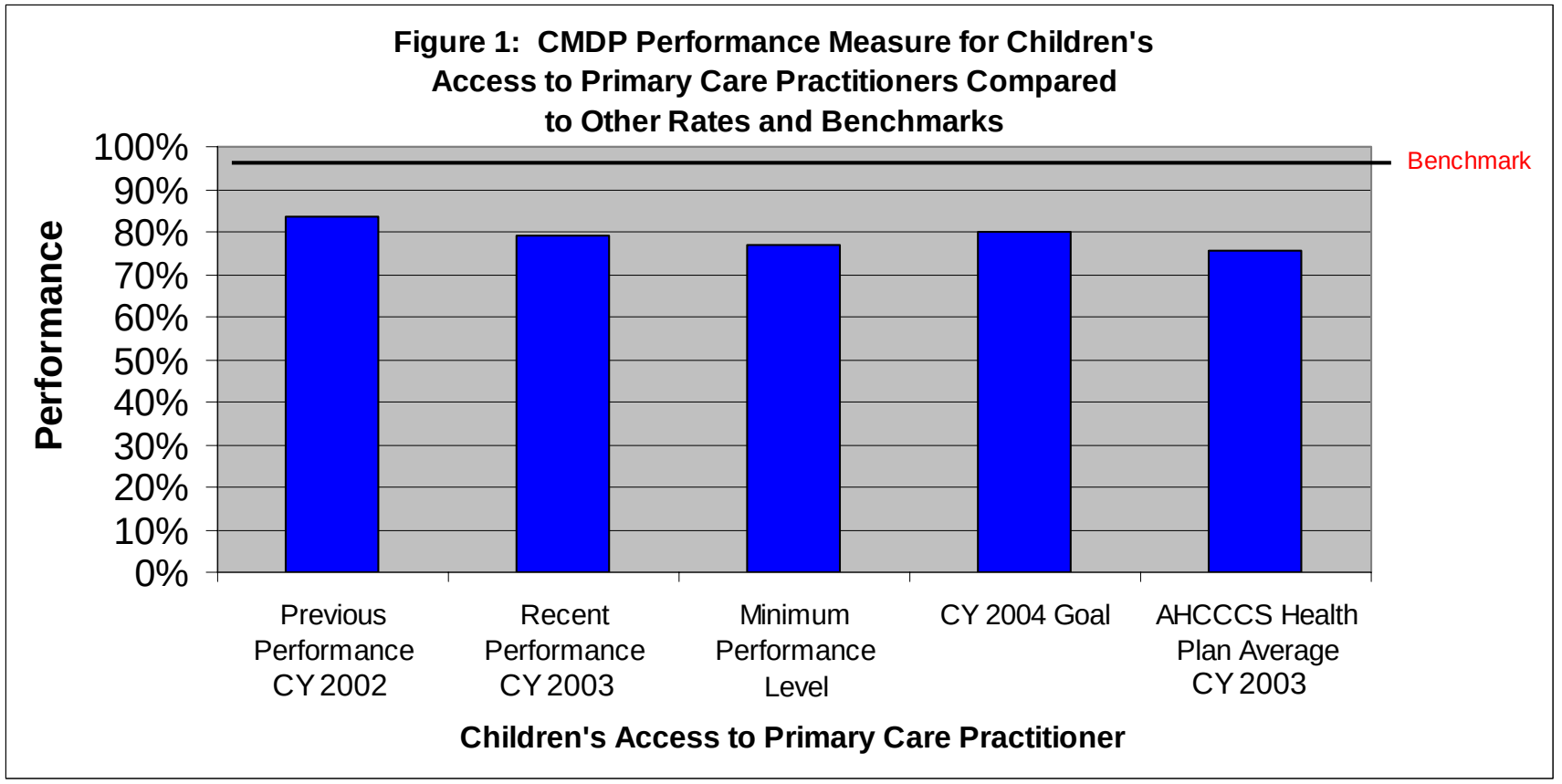
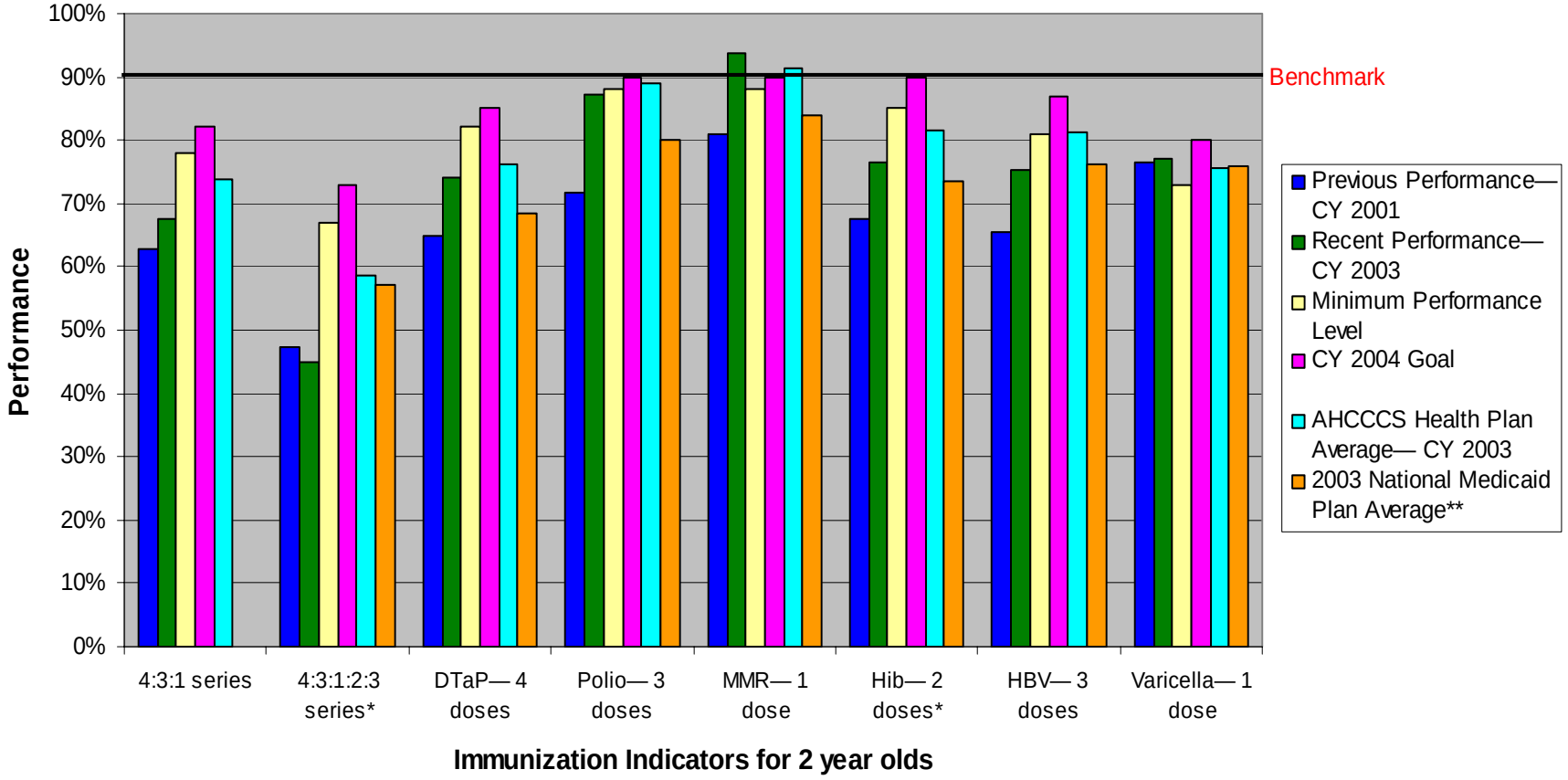


Table 2: CMDP Performance Measures for Immunization Completion Rates at 24 Months of Age Compared to Other Rates and Benchmarks							
Immunization Indicators for 2 Year Olds	Previous Performance	Recent Performance	Minimum Performance Level	CY 2004 Goal	AHCCCS Health Plan Average	2003 National Medicaid Plan Average**	Benchmark
	CY 2001	CY 2003			CY 2003		
4:3:1 series	62.8%	67.7%	78%	82%	73.7%	0.0%	90%
4:3:1:2:3 series*	47.3%	44.9%	67%	73%	58.6%	57.2%	90%
DTaP— 4 doses	64.9%	74.1%	82%	85%	76.1%	68.4%	90%
Polio— 3 doses	71.6%	87.3%	88%	90%	89.1%	80.1%	90%
MMR— 1 dose	81.1%	93.7%	88%	90%	91.4%	83.9%	90%
Hib— 2 doses*	67.6%	76.6%	85%	90%	81.5%	73.5%	90%
HBV— 3 doses	65.5%	75.3%	81%	87%	81.2%	76.1%	90%
Varicella— 1 dose	76.4%	77.2%	73%	80%	75.5%	76.0%	90%

* For 2003 National Medicaid Plan Average, HEDIS® measure includes 3 Hib doses, compared to 2 Hib doses required by AHCCCS

** NCQA. HEDIS® *Medicaid Audit Mean, Percentiles & Ratios.*
www.ncqa.org/Programs/HEDIS/Audit?HEDIS_2003_Audit_Means_ratios.htm

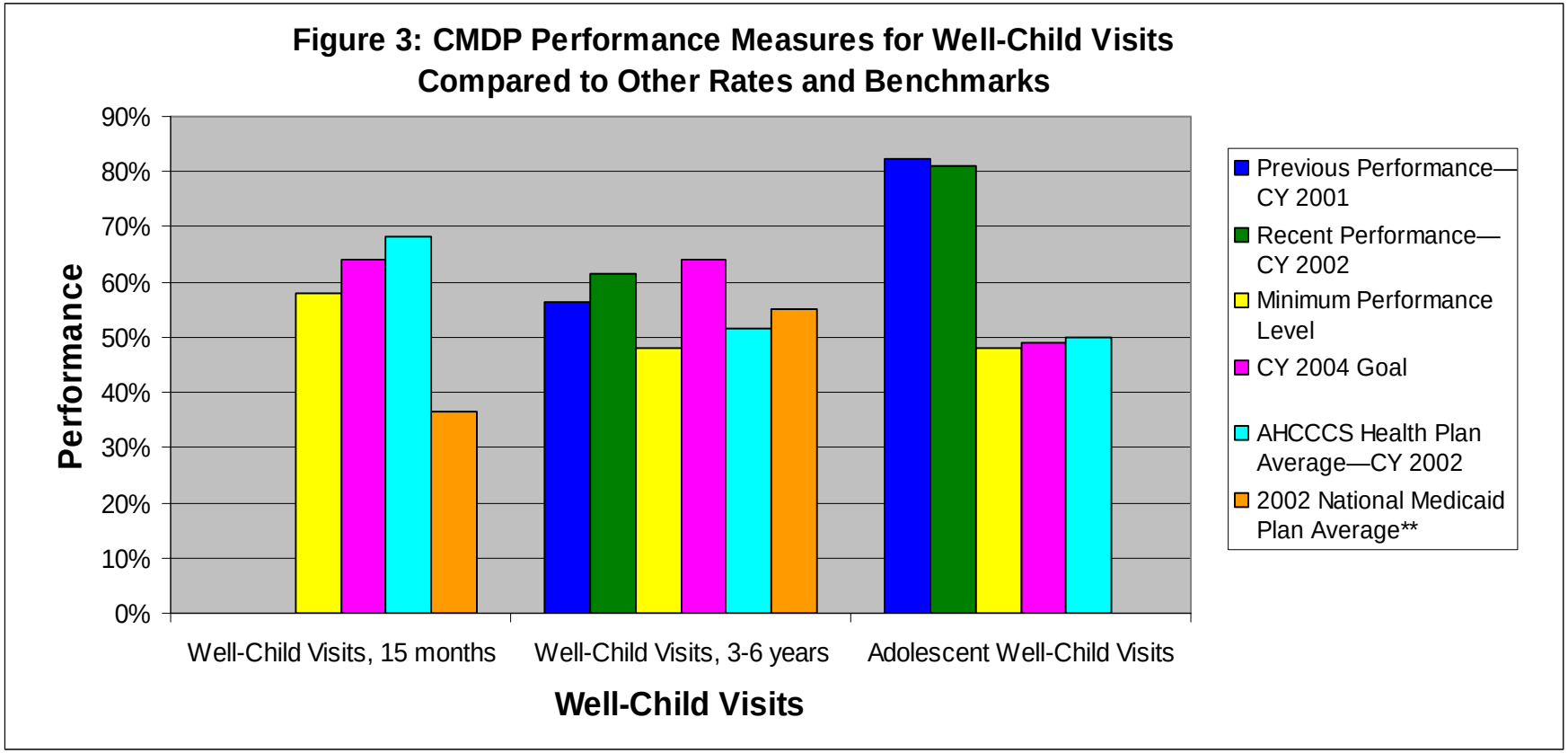
Figure 2: CMDP Performance Measures for Immunization Completion Rates at 24 Months of Age Compared to Other Rates and Benchmarks



* For 2003 National Medicaid Plan Average, HEDIS® measure includes 3 Hib doses, compared to 2 Hib doses required by AHCCCS

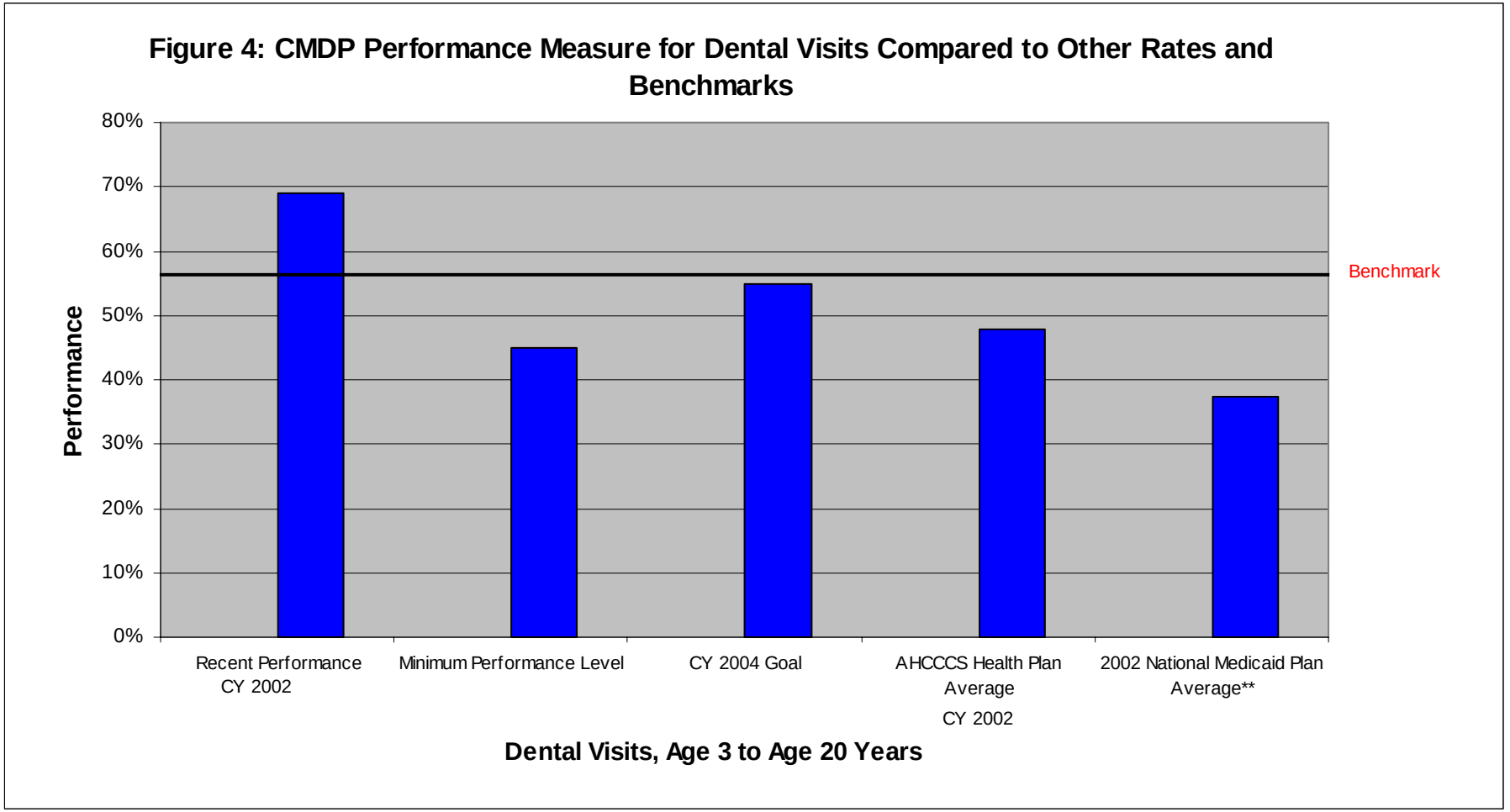
**NCQA. HEDIS® Medicaid Audit Mean, Percentiles & Ratios. www.ncqa.org/Programs/HEDIS/Audit?HEDIS_2003_Audit_Means_ratios.htm

Table 3: CMDP Performance Measures for Well-Child Visits Compared to Other Rates and Benchmarks							
Well-Child Visits (0-20 years)	Previous Performance	Recent Performance	Minimum Performance Level	CY 2004 Goal	AHCCCS Health Plan Average	2002 National Medicaid Plan Average**	Benchmark
	CY 2001	CY 2002			CY 2002		
Well-Child Visits, 15 months	n/a	58%*	58%	64%	68.1%	36.6%	90%
Well-Child Visits, 3-6 years	56.4%	61.4%	48%	64%	51.5%	55.1%	80%
Adolescent Well-Child Visits	82.4%	80.9%	48%	49%	50.0%	N/A	50%
* Sample size insufficient to yield valid conclusions ** NCQA. HEDIS® *Medicaid Audit Mean, Percentiles & Ratios. HEDIS® methodology varies slightly from AHCCCS methodology.*							



** NCQA. HEDIS® Medicaid Audit Mean, Percentiles & Ratios. HEDIS® methodology varies slightly from AHCCCS methodology.

Table 4: CMDP Performance Measure for Dental Visits Compared to Other Rates and Benchmarks							
Dental Visits	Previous Performance	Recent Performance	Minimum Performance Level	CY 2004 Goal	AHCCCS Health Plan Average	2002 National Medicaid Plan Average**	Benchmark
	CY 2001	CY 2002		CY 2002			
Dental Visits, 3-20 years	n/a	68.9%	45%	55%	47.8%	37.4%	56%
** NCQA. HEDIS® Medicaid Audit Mean, Percentiles & Ratios. HEDIS® methodology varies slightly from AHCCCS methodology.							

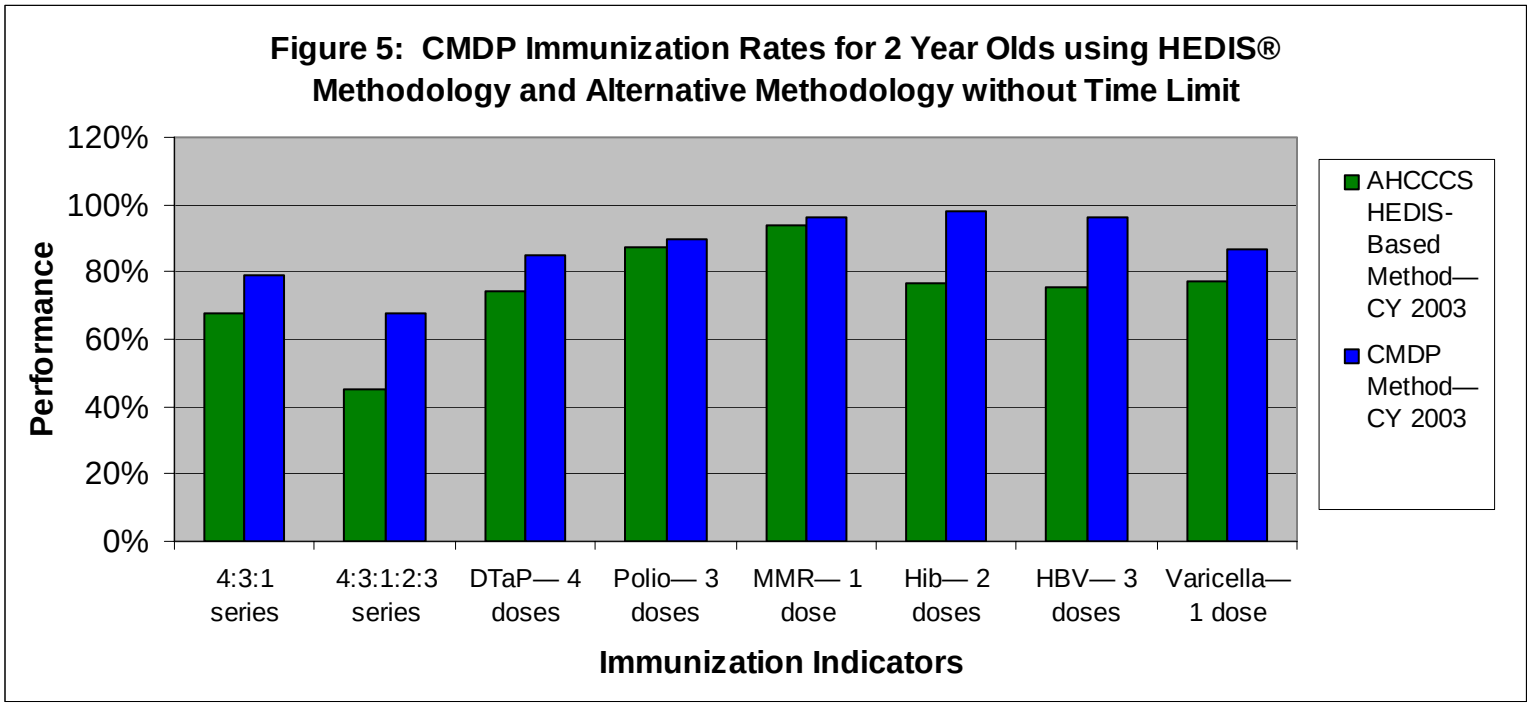


** NCQA. HEDIS® Medicaid Audit Mean, Percentiles & Ratios. HEDIS® methodology varies slightly from AHCCCS methodology.

Overall, based on the mandated performance measure results for the measurement periods ending September 30, 2002 and 2003, CMDP appeared to be operating an effective service delivery system in terms of appropriate access and/or availability to and use of services. For all the non-immunization related performance measures, CMDP exceeded the AHCCCS minimum performance standards. Particularly notable was CMDP's performance measures for dental visits[2] and adolescent well-care visits, two areas in which historically both AHCCCS acute care health plans, as well as Medicaid health plans nationally, have scored low. For these two measures CMDP not only met the AHCCCS benchmarks but scored higher in these areas than the other acute care health plans. Additionally, except for the measure for children's access to Primary Care Practitioners, CMDP rates increased for all of its performance measures.[3]

For the immunization performance measures in 2003, CMDP only met the AHCCCS minimum performance standards for MMR1 doses and Varicella. However, as discussed in Section III related to the immunization Performance Improvement Projects, CMDP has continued to make improvements in its immunization rates. When CMDP recalculated the rates, eliminating the HEDIS® specifications for timeliness, the rates were substantially higher. CMDP stated that the HEDIS®-based methodology for timeliness led to low rates of immunization compliance for the foster care population, due to the fact that the majority of CMDP members are removed from their home because of neglect and often are on catch-up immunization schedules. Table 5 and Figure 5 compare the complete antigen series and the individual antigen immunization rates recalculated by CMDP, which excluded the HEDIS® specifications for timeliness, to the AHCCCS calculated rates, which used the HEDIS®-based methodology for timeliness.

Table 5: CMDP Immunization Rates for 2 Year Olds using HEDIS® Methodology and Alternative Methodology without Time Limit		
Immunization Indicators for Two Year Olds	**AHCCCS HEDIS-Based Method**	**CMDP Method**
	CY 2003	**CY 2003**
4:3:1 series	68%	79%
4:3:1:2:3 series	45%	68%
DTaP— 4 doses	74%	85%
Polio— 3 doses	87%	90%
MMR— 1 dose	94%	96%
Hib— 2 doses	77%	98%
HBV— 3 doses	75%	96%
Varicella— 1 dose	77%	87%



2. Interventions and Corrective Action Plans

In contract year 2004, as part of its Quality Management/Performance Improvement work plan, CMDP proposed to improve its performance measure rates by 10% for dental visits, well-child visits (15 months and 3 through 6 years), adolescent well-care visits, and access to Primary Care Practitioners. It also proposed to monitor cervical cancer screening with the performance goal being 90% of sexually active females 16 years or older. In addition to its Quality Management/Performance Improvement work plan, CMDP was required by AHCCCS to submit a corrective action plan due to its low rates for certain childhood immunizations. (Refer to Section III for additional details on the corrective action plan.)

E. Conclusions

As required by 42 CFR 438.240(c), AHCCCS established a set of performance measures and standards by which it is able to assess CMDP's performance related to the provision of quality care to its members. Using HEDIS® methodology as a guideline, AHCCCS established detailed specifications for calculating the measures and more recently adopted the NCQA rotation schedule for monitoring performance measures. AHCCCS, which has assumed responsibility for validation of the performance measures, also established quality control and study validation procedures to ensure consistent and accurate data are used in the production of its performance measure reports. During this EQRO Annual Report review period, AHCCCS issued two separate reports that contained CMDP performance measure results. The reported results were used to identify areas in which CMDP did not meet the AHCCCS minimum performance levels (e.g., certain immunization rates), thereby requiring the development of a corrective action plan by CMDP to improve its performance. However, except in the area of immunization, CMDP's performance met or exceeded the AHCCCS minimum performance levels, especially in the area of dental visits and well-child visits.

Notes

[1] AHCCCS refers to performance measures as performance indicators, but since the term used by CMS is performance measures, that term is used throughout this report.

[2] As part of the AHCCCS Performance Improvement Project for Children's Oral Health Visits, AHCCCS measured the percent of CMDP enrolled members ages 3 through 8 years who had any dental visit between October 1, 2001 and September 30, 2002. For this younger group, the percentage of CMDP members with a dental visit was 44.7%, which was substantially lower than the other AHCCCS contracted acute care health plans (57% for Medicaid members).

[3] The measure for EPSDT participation was not included in the AHCCCS performance measure reports. AHCCCS intends to report this measure in 2005.

III. REVIEW, ANALYSIS, AND SUMMARY OF PERFORMANCE IMPROVEMENT PROJECT

A. Objectives

Performance Improvement Projects (PIP) are included as part of the overall *AHCCCS Quality Assessment and Performance Improvement Strategy* and are used as a key strategy by AHCCCS to measure, assess, and improve the quality and appropriateness of care and/or services provided to AHCCCS-enrolled members. As set forth in contract and detailed in the *AHCCCS Medical Policy Manual*, all acute care health plans (including CMDP) are required to initiate a new PIP each year.[1] CMDP's proposal for its new PIP must be included as part of its Quality Management/Performance Improvement Plan, which is submitted annually to AHCCCS for review and approval. In addition to contractor-selected PIPs, AHCCCS also requires CMDP to participate in a limited number of AHCCCS-mandated PIPs. These state-mandated PIPs are intended to focus on topics that are specific to AHCCCS or related to statewide topics and/or involve AHCCCS or the Centers for Medicare & Medicaid Services (CMS) performance measures.[2] The selection process for AHCCCS-mandated PIPs also involves analysis of internal and external data and trends, and solicitation of input on potential topics from the acute care health plans.

1. General PIP Requirements

Using federal regulations and guidance related to PIPs,[3] AHCCCS established detailed policies and procedures, and templates for conducting PIPs, which are set forth in the *AHCCCS Medical Policy Manual—980* Performance Improvement Projects, Selection and Assessment and the *PIP Methodology Template*. As required in 42 CFR 438.236, key components of all AHCCCS (state and contractor-selected) PIPs include the following features.

- Identifying clinical or non-clinical areas for improvement
- Gathering baseline data from administrative data and other sources
- Designing and implementing interventions
- Measuring the effectiveness of the intervention
- Maintaining and sustaining the improvement

The timeframe established by AHCCCS for each PIP is a minimum of four years. Baseline data and proposed interventions must be reported at the end of year one, an interim report on results of re-measurement of performance to determine demonstrable improvements at the end of the third year, and a final report on the results of re-measurement of performance to determine if sustained improvement has been achieved during the fourth year.

As discussed in Section II, AHCCCS also has written procedures to ensure the collection of valid and reliable data for performance measures and PIPs.

2. Focus of EQRO Review

For purposes of this EQRO Annual Report, AHCCCS limited the review to the AHCCCS-mandated PIP in the third year of the PIP cycle. For the acute care health plans, this would have been the AHCCCS-mandated diabetes PIP. However, this PIP had minimal applicability to CMDP since it only had one member with diabetes who met the continuous enrollment criteria for the PIP. Thus, for purposes of this report, AHCCCS requested review of the state-mandated PIP on immunizations.

The AHCCCS-mandated immunization PIP represents a unique situation. In contract year 2004, as a result of statistically significant decreases in AHCCCS' overall rates for immunization for three individual vaccinations (DTaP, Hib and VZV) and both immunization series, AHCCCS decided to initiate a PIP to improve the acute care health plans' immunization performance rates, and to ensure the achievement of AHCCCS minimum performance standards and goals. However, unlike most PIPs, the timeframe for this PIP was compressed by AHCCCS such that when it was initiated the PIP was considered to be in the third year of the PIP cycle. This was due to the fact that AHCCCS had previously collected baseline data on immunizations as part of its biennial immunization performance rates study conducted in contract year 2003, and that the acute care health plans had already identified and implemented interventions as a result of the 2003 study. Thus, during contract year 2004, AHCCCS conducted a re-measurement study of CMDP's immunization rates (along with all acute care health plans) to determine the effect of the interventions that had been implemented.[4]

For CMDP, reviewing the AHCCCS-mandated immunization PIP was further complicated by the fact that CMDP had implemented a contractor-selected PIP on immunization rates in contract year 2003. Thus, six months prior to the implementation of the AHCCCS-mandated immunization PIP, CMDP submitted a report on baseline data and proposed intervention strategies to AHCCCS for approval as part of its Quality Management/Process Improvement Plan.[5]

B. Description of Data and Data Collection Methodology

In its PIP proposal for immunizations[6] AHCCCS clearly describes its data collection methodology which, in general, follows HEDIS® 2003 specifications. The data collection methodology is a hybrid method using administrative data together with medical record review as needed for the numerator. AHCCCS employed the same methodology to collect the baseline data (measurement period October 1, 2002 through September 30, 2003) and the re-measurement data (measurement period October 1, 2003 through September 30, 2004). Additionally, AHCCCS contracted with Health Services Advisory Group (HSAG), an external quality review organization, to coordinate the data collection and to aggregate and analyze the results for both assessments. All involved parties in the PIPs were required by AHCCCS to adhere to federal and state confidentiality laws and regulations.

1. Sample Selection

Using enrollment data extracted from the AHCCCS PMMIS recipient subsystem, AHCCCS pulled a representative sample of children for the denominator. Children who turned two years old during the measurement period were included in the sample if they had at least 12 months of continuous enrollment with the same acute care health plan, prior to and including their second birthdays. One break in enrollment of up to 31 days during the 12 month period was allowed. The sample selection was calculated to provide a 99% confidence level and 5% confidence interval. Based on its past experience with immunization studies, AHCCCS over-sampled by 5% to ensure the validity of the sample size.

2. Immunization Data

To maximize its ability to obtain complete data on the selected sample, AHCCCS first queried available administrative data (i.e., immunization data) for this sample population from the Arizona State Immunization Information System (ASIIS).[7] Immunization data were collected for the following vaccines.

- Diphtheria, Tetanus Toxoids, and Acellular Pertussis (DTaP)
- Inactivated Poliovirus Vaccine (IPV)
- Measles, Mumps, and Rubella (MMR)
- Haemophilus Influenza Type B (HIB)
- Hepatitis B (HBV)
- Varicella Zoster Virus Vaccine (VZV)
- Pneumococcal Conjugate Seven-Valent Vaccine (PCV-7)

Since PCV-7 data had not been collected during previous immunization studies, additional information was to be gathered on reasons why the vaccine was not given, deferral reasons and dates, partial series vaccine dates, and refusal reasons.

If the child's ASIIS record contained all the required immunizations, the child's record was considered to be complete. For any member of the sample who had incomplete or missing immunizations in their ASIIS record, CMDP was required to collect the additional immunization data in accordance with HEDIS® methodology by either reviewing medical records or using administrative (claims) information. CMDP then submitted the completed electronic data files to HSAG. HSAG was responsible for validating all logical field-to-field comparisons that exist in the data sets from CMDP and the other acute care health plans. This "clean" data was then merged with the ASIIS data and the original sample file.

C. Review of Analysis Methodology

HSAG also was responsible for the data analysis which, like the data collection methodology, followed HEDIS® specifications. Additionally, as with the data collection methodology, AHCCCS described the analysis methodology in its PIP proposal, including a detailed description of how the indicators would be calculated as well as the basic analytical approach.

1. Quality Performance Measures

AHCCCS used HEDIS® 2003 specifications to define its primary quality performance measures for both individual immunization rates for DTaP, IPV, MMR, HIB, HBV, and VZV and for the combination series 4:3:1:3:3.[8] AHCCCS also continued to report on the Healthy People 2000 three-antigen combined immunization rate (4:3:1). For each of these measures, AHCCCS established minimum performance standards, goals, and benchmarks (refer to Section II on performance measures). These primary quality performance measures were applied to all the acute care health plans, including CMDP.

In addition to these primary performance measures, AHCCCS included two additional quality performance measures to provide the acute care health plans with more information for assessing their immunization rates. These included the following measures.

- PCV-7 immunization rate, which followed the recommended time by the Advisory Committee on Immunization
- HEDIS® combination series 4:3:1:3:3:1, which reflects the addition of the PCV-7

2. Analysis Approach

For the baseline PIP report on childhood immunizations, the analysis included the following components.

- The percentage of 2-year old members who were age appropriately immunized by 24 months for each of the quality performance measures by acute care plan
- Identification of missed opportunities for DTaP vaccination by acute care health plan and by county

During the baseline year, immunization completion rates of children beyond their second birthday also were conducted because of national vaccine shortages and delays in shipping product during the time that children in the sample should have received immunizations. This information was only analyzed in the aggregate, not by individual acute care health plans.

In addition to summarizing the individual results for CMDP, comparative analysis was conducted which compared the CMDP results to the following list.[9]

- Previous measurement periods
- AHCCCS minimum performance standards, goals, and benchmarks
- NCQA Medicaid HEDIS® health plan averages
- Other AHCCCS contracted acute care health plans

Stata statistical code[10] was used to generate vaccine-specific and combination immunization rates based on the AHCCCS quality indicator criteria for immunizations.

The baseline study results and analysis were summarized in a report entitled *Arizona Health Care Cost Containment System Biennial Report of Immunization Completion Rates by Months of Age*, March 2004. While preliminary results from the re-measurement study were made available for this EQRO Annual Report, the actual final re-measurement report was not completed in time for this review. The final re-measurement report is expected to be released during the summer of 2005.

D. Assessment of Strengths and Weakness

1. PIP Results

The results from the AHCCCS-mandated immunization PIP for the baseline measurement and re-measurement studies in 2003 and 2004, respectively, are shown in Table 6 and Figure 6. Additionally, the AHCCCS health plan averages and the NCQA 2003 Medicaid HEDIS® health plan averages also are included in Table 6 and Figure 6 for comparison purposes. The shaded results in the baseline and re-measurement column of the table indicate that CMDP met the AHCCCS minimum performance level.

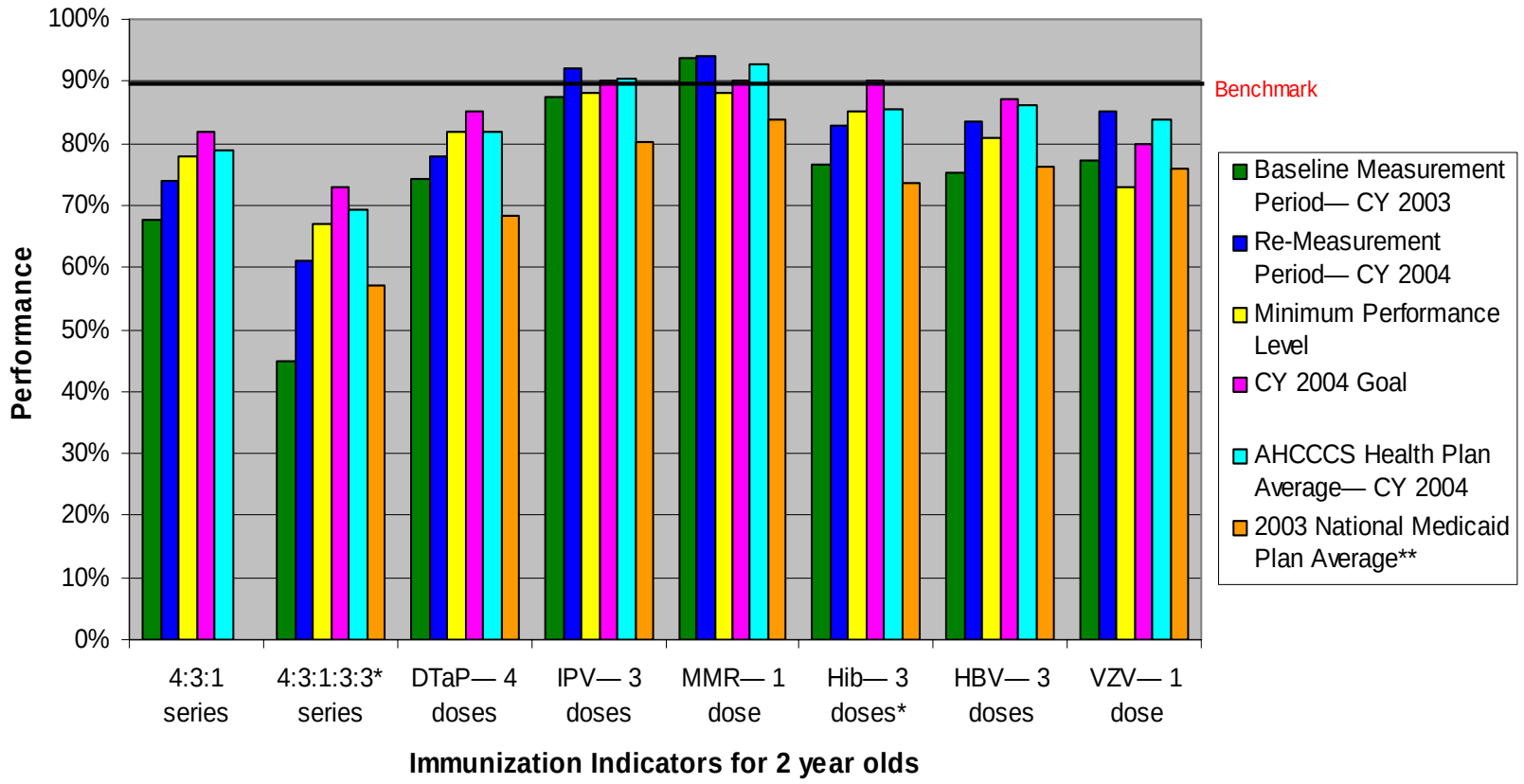
Table 6: CMDP Baseline and Re-measurement Results for AHCCCS Performance Improvement Project on Immunization Rates at 24 Months of Age

Immunization Indicators for 2 Year Olds	Baseline Measurement Period	Re-measurement Period	Minimum Performance Level	CY 2004 Goal	AHCCCS Health Plan Average	2003 National Medicaid Plan Average**	Benchmark
	CY 2003	CY 2004		CY 2004			
4:3:1 series	67.7%	74.0%	78%	82%	78.9%	0.0%	90%
4:3:1:3:3* series	44.9%	61.0%	67%	73%	69.3%	57.2%	90%
DTaP— 4 doses	74.1%	78.0%	82%	85%	81.8%	68.4%	90%
IPV— 3 doses	87.3%	92.0%	88%	90%	90.4%	80.1%	90%
MMR— 1 dose	93.7%	94.0%	88%	90%	92.6%	83.9%	90%
Hib— 3 doses*	76.6%	83.0%	85%	90%	85.4%	73.5%	90%
HBV— 3 doses	75.3%	83.5%	81%	87%	86.1%	76.1%	90%
VZV— 1 dose	77.2%	85.0%	73%	80%	83.8%	76.0%	90%

*For CY 2003, only two doses of Hib were measured; thus, the five-antigen series measured was 4:3:1:2:3.

** NCQA. HEDIS® *Medicaid Audit Mean, Percentiles & Ratios.*

Figure 6: CMDP Baseline and Re-measurement Results for AHCCCS Performance Improvement Project on Immunization Rates at 24 Months of Age



* For CY 2003, only two doses of Hib were measured; thus, the five-antigen series measured was 4:3:1:2:3.

** NCQA. HEDIS® Medicaid Audit Mean, Percentiles & Ratios.

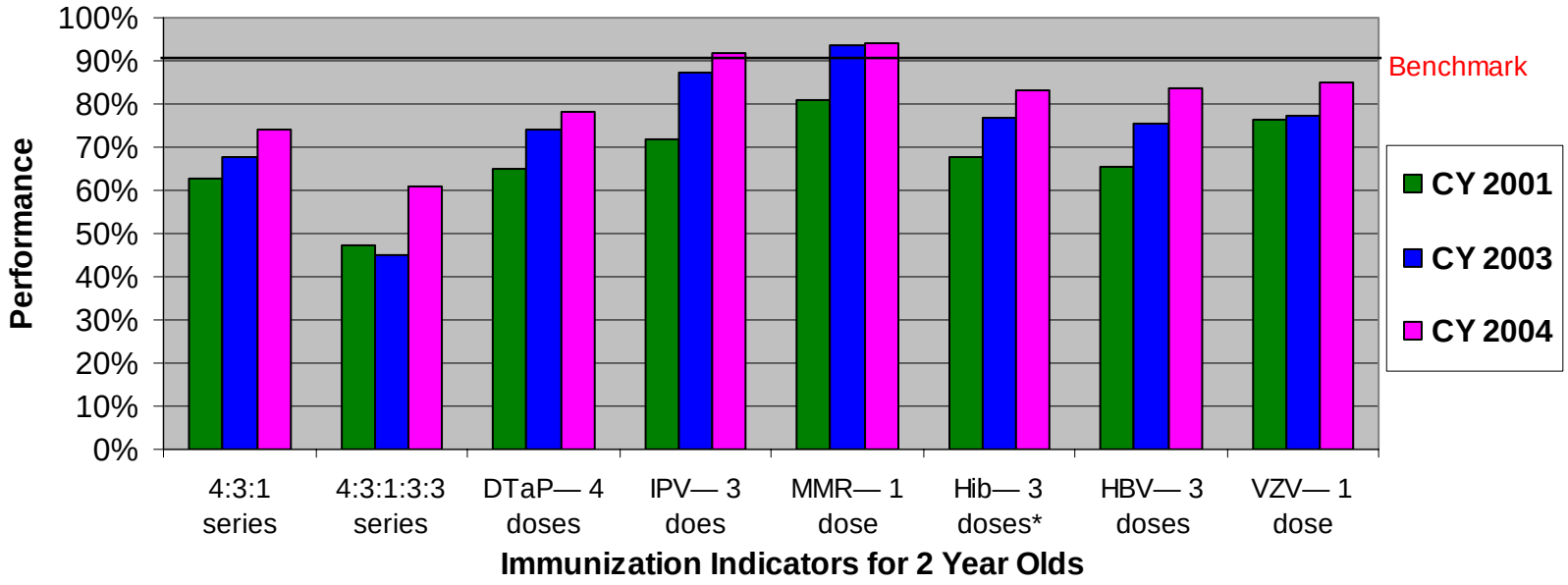
During the re-measurement period, there was a notable improvement in CMDP's immunization completion rates, such that CMDP now meets the AHCCCS minimum performance level for four individual immunization rates as compared to two during contract year 2003. (AHCCCS is still in the process of calculating whether there was a statistical increase in rates from the previous years.) This increase is consistent with the success CMDP has had in steadily increasing its immunization completion rates over the past four years (refer to Table 7 and Figure 7). Additionally, all of CMDP's 2004 rates are higher than the NCQA 2003 Medicaid HEDIS® health plan averages. However, when compared to the AHCCCS Medicaid average for all acute care health plans, CMDP immunization rates were higher only for IPV, MMR, and VZV (refer to Section II regarding CMDP's recalculation of its immunization rates using a different methodology).

Table 7: Comparison of CMDP Immunization at 24 Months of Age and by Contract Year

Immunization Indicators for 2 Year Olds	Performance			Benchmark
	CY 2001	CY 2003	CY 2004	
4:3:1 series	62.8%	67.7%	74.0%	90%
4:3:1:3:3 series	47.3%	44.9%	61.0%	90%
DTaP— 4 doses	64.9%	74.1%	78.0%	90%
IPV— 3 does	71.6%	87.3%	92.0%	90%
MMR— 1 dose	81.1%	93.7%	94.0%	90%
Hib— 3 doses*	67.6%	76.6%	83.0%	90%
HBV— 3 doses	65.5%	75.3%	83.5%	90%
VZV— 1 dose	76.4%	77.2%	85.0%	90%

* For CY 2003, only two doses of Hib were measured; thus, the five antigen series measured was 4:3:1:2:3.

Figure 7: Comparison of CMDP Immunization Rates at 24 Months of Age and by Contract Year



* For CY 2003, only two doses of Hib were measured; thus, the five antigen series measured was 4:3:1:2:3

2. Interventions

CMDP implemented a number of interventions to improve its immunization rates. These interventions were developed in response to the following requirements.

- 2003 CMDP-selected PIP on immunization
- AHCCCS requirement to submit a corrective action plan to improve immunization rates since CMDP only met the AHCCCS minimum performance standard for MMR1 doses and Varicella in contract year 2003

In June 2004, CMDP submitted the corrective action plan identifying interventions it would implement to improve its immunization rates. Based on the AHCCCS response, the corrective action plan was modified and subsequently approved by AHCCCS in September 2004. The following were CMDP's proposed interventions.

- Identify members who are behind on immunizations (18-month old instead of 20-month old)
- Improve immunization records through identification of alias names, elimination of duplicate ASIIS records, improved system edits, and educating providers on data entry into ASIIS through provider newsletters and on-site visits
- Expedite receipt of ASIIS information on all children at the time of removal from their homes
- Educate providers to recall members who had immunizations deferred, using provider newsletters and on-site visits
- Educate caregivers on importance of ensuring immunizations are complete and up-to-date through member newsletters and case manager education

AHCCCS tracks the implementation of these interventions through the CMDP quarterly EPSDT Progress Report in which CMDP provides updates on its immunization corrective action plan activities. It is difficult to determine how successful CMDP has been in its implementation of its proposed interventions from these reports. The quarterly progress report from July through September that was provided for the review was limited in terms of its report on CMDP's progress in implementing the interventions and evaluating their effectiveness. The progress report only reported that providers were being reminded to make sure immunization data were being submitted into the ASIIS system on a regular basis and that EPSDT forms were being matched against the ASIIS system with EPSDT coordinators updating the information into ASIIS, as appropriate.

E. Conclusions

Performance Improvement Projects play an integral role in AHCCCS' quality assessment and performance improvement strategy. Through both the AHCCCS-mandated as well as CMDP-selected PIPs, AHCCCS has been able to assess and improve the quality and appropriateness of care and/or services in targeted areas. AHCCCS articulated its expectations for the design of PIPs, and validation of data methodology and study

findings in both policies and in special acute care health plan presentation materials. The AHCCCS-mandated immunization PIP was designed and conducted in accordance with CMS recommended PIP protocols, in that it addressed all of the following components.

- Selection of the topic was based on an evaluation of health plan data
- Study question was clearly articulated in the AHCCCS PIP proposal
- Quality measures were established using existing managed care industry standards (HEDIS®)
- A reliable sampling methodology was used for selecting the study population
- The PIP proposal, as well as the baseline report, clearly articulated the data collection and analysis procedures
- AHCCCS reviewed and approved CMDP's improvement strategies and established a process for submittal of updates
- An EQRO conducted an analysis of the PIP findings
- AHCCCS had an established process of calculating whether re-measurement was statistically significant

The preliminary results from the re-measurement study revealed that CMDP is continuing to make progress in improving its immunization rates through its planned intervention strategies.

Notes

[1] CMDP-selected PIPs included children's dental visits in CY 02, immunization in CY 03 and EPSDT screens in CY 04.

[2]AHCCCS mandated PIPs have included diabetes in CY 02, children's oral health in CY 03, and childhood immunization in CY04.

[3] Refer to 42 CFR 438.236 and Centers for Medicare & Medicaid Services protocols for conducting performance improvement projects.

[4] The re-measurement study is generally conducted during the third year of a PIP project. In the case of the AHCCCS-mandated immunization PIP, it was conducted earlier.

[5] A copy of the CMDP report was not provided by AHCCCS as part of this review. Based on an AHCCCS letter to CMDP commenting on the report, it is assumed that such a document was submitted.

[6] Arizona Health Care Cost Containment System (AHCCCS), CYE 2005 Acute Care Contractor Performance Project (PIP): Immunization of 2-Year-Olds.

[7] Providers in Arizona are required to report all immunizations given to all children up to the age of 18 years to this automated registry maintained by the Arizona Department of Health Services.

[8] During the re-measurement study, the five-antigen series 4:3:1:3:3:1 replaced the previous measure 4:3:1:2:3. This change was due to the fact that the standard for HIB was increased from two to three doses.

[9] For CMDP the analysis was limited to only Title XIX members as compared to a separate analysis on KidsCare (Title XXI) members. CMDP membership is primarily comprised of Title XIX members, with an insignificant number of KidsCare enrollees.

[10] For more information about Stata, go to http://www.stat.com/products/overview.

IV. REVIEW, ANALYSIS, AND SUMMARY OF AHCCCS COMPLIANCE WITH MEDICAID MANAGED CARE FEDERAL AND STATE REGULATIONS

A. Objectives

The Balanced Budget Act of 1997 (BBA) requires AHCCCS, as the Medicaid agency, to determine CMDP's compliance (as a managed care organization) with the BBA regulatory provisions related to quality standards. An overview of the approach taken by AHCCCS to ensure services provided to members meet or exceed established quality related standards is contained in the *AHCCCS Quality Assessment and Performance Improvement Strategy*, which is a requirement of the BBA (42 CFR 438.202). As noted in the CMS protocol,[1] determining health plan compliance entails a two step process.

- Establishing standards for quality health care
- Determining the extent to which the managed care organizations comply with the federal quality standards for managed care organizations

1. Establishment of Quality Health Care Standards

As it relates to the first requirement, AHCCCS established quality standards for CMDP to follow that are in compliance with the BBA regulatory provisions. These requirements are included in the contract between AHCCCS and CMDP, (10/01/03 through 12/31/04). This contract has been reviewed and approved by CMS as meeting all BBA requirements. Additional specificity on the BBA-related requirements is contained in contract referenced regulations, AHCCCS policy manuals (e.g., *AHCCCS Medical Policy Manual*), and other AHCCCS technical documents. It is these same standards to which CMDP is held when AHCCCS is determining its compliance with the federal quality standards for managed care organizations.

2. Determination of Compliance with Quality Health Care Standards

AHCCCS used four different strategies to assess CMDP's compliance with federal (BBA) and state regulatory provisions related to quality standards.

a. Annual Operational and Financial Review. While federal regulations only require a compliance review to be conducted within a three year period (42 CFR 438.358), AHCCCS is required by state regulation to conduct a program compliance audit at least every 12 months (ACC R9-22-52). The 2004 operational and financial review (OFR) included the following primary objectives.[2]

- Determine if CMDP satisfactorily met AHCCCS requirements as specified in contract, policy, and rule
- Increase AHCCCS knowledge of CMDP's operational and financial procedures

- Provide technical assistance and identify areas in which improvements can be made, as well as identify areas of noteworthy performance and accomplishments
- Review the progress made toward implementing the recommendations made during prior reviews
- Determine if CMDP is in compliance with its own policies and procedures and evaluate the effectiveness of those policies and procedures
- Provide oversight as required by CMS in accordance with AHCCCS 1115 waiver
- Provide information for use in the CMS required annual EQRO Annual Report for health plans

b. Review of Health Plan Documents. AHCCCS required that numerous CMDP-related reports and documents (e.g., Quality Management/Process Improvement plan, member handbook, and provider network) be reviewed and approved by AHCCCS during the 2004 contract year. This review strategy afforded AHCCCS the opportunity to take a more proactive approach in its compliance oversight role by being able to immediately remedy any compliance issues during the contract year rather than wait until the issue was identified during the annual operational and financial review.

c. Review and Analysis of Program Specific Performance Measures. For each acute care health plan, including CMDP, AHCCCS reviewed and analyzed standard performance measures in relation to minimum performance levels, goals, and benchmarks. The analysis of CMDP's performance allowed AHCCCS to evaluate how successful CMDP was in providing care to its members as well as to identify areas for quality improvement by CMDP.

d. Review and Analysis of Performance Improvement Projects. During contract year 2004, CMDP was required to submit to AHCCCS, for review and approval, specific reports related to PIPs. These projects were intended to improve CMDP's quality of care and service delivery in targeted areas. From these reports AHCCCS was able to monitor the implementation and success of CMDP's performance improvement intervention strategies.

The remainder of this section will focus on the first two strategies described above—the OFR and review of acute care health plan documents. A more detailed discussion of the latter two strategies is provided in Sections II and III.

B. Description of Data and Data Collection Methodology

1. Operational and Financial Review

Descriptions of the data and data collection methodology to be used for the contract year 2004 OFR of CMDP are contained in the following AHCCCS documents.

- *AHCCCS-CMDP Contract*, Section D.18 – Operational and Financial Review
- *AHCCCS Health Plan Operational and Financial Reviews,* which is an internal AHCCCS document that described in more detail the review process procedures including: pre-review activities for team leaders, on-site review policies and protocols, instructions for completing the review report, and process for reviewing and approving any corrective action plans
- An overview of the operational and financial review process which was posted on the Plans & Providers section of the AHCCCS web site found at http://www.ahcccs.state.az.us/Publications/ProviderTraining/Monitoring/OpFinReviews.asp
- The *CYE 04 Operational and Financial Review Tool,* which included a general description of the review process and objectives as well as identified all the review standards. The same tool was used for the compliance reviews of all acute care health plans, including CMDP.

The data and data collection methodology used by AHCCCS to conduct the OFRs followed the basic protocol activities recommended in the CMS *Protocol for Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).*

The specific type of data collected by AHCCCS was targeted at documenting CMDP's compliance with the standards set forth in the *CYE 2004 AHCCCS Operation and Financial Review Tool*. As recommended in the CMS protocol, AHCCCS used data obtained through document review, as well as information obtained through interviews with CMDP personnel, to determine compliance. AHCCCS also used "observation," in which on-site reviewers accompanied plan personnel and observed day-to-day operations in up to five different areas.[3]

The data collection methodology described in the AHCCCS internal protocol document consisted of the following two key activities.

a. Pre-Review Activities. Prior to the on-site visit, AHCCCS specified which health plan documentation was to be obtained from CMDP and it was reviewed by appropriate AHCCCS review team members. A review team meeting was then held to discuss basic health plan facts.

b. On-Site Review Activities. The AHCCCS on-site health plan review activities generally are conducted over a three to five day period. The on-site operational and financial review for CMDP was conducted from January 24 to January 27, 2005. AHCCCS provided CMDP with a list of specific documents they were to make available during the on-site review. After reviewing these documents, the AHCCCS review team conducted pre-scheduled interviews with CMDP personnel and completed any on-site observations of day-to-day operations.

The review team for CMDP consisted of 18 individuals from AHCCCS administration, representing different areas of expertise within the agency (e.g., financial compliance

audit, grievance and appeal, medical management). The review was organized around the following program areas: general administration, delivery system (i.e., provider development and management), member services, grievance system, behavioral health, utilization management, quality management, maternal child health, financial management, reinsurance, encounters, and claims. The AHCCCS review team members were divided into sub-teams according to their expertise, with each sub-team being assigned responsibility for reviewing a specific program area(s). A copy of the OFR tool, which identified the standards being used by the AHCCCS reviewers to measure compliance, was provided to CMDP prior to the on-site review. Twenty individuals from CMDP participated in the review, including all the key management staff as well as other key program staff (e.g., EPSDT coordinator, accountant, dental consultant).

2. Review of Health Plan-Related Documents

In its contract with CMDP and in the *AHCCCS Medical Policy Manual*, AHCCCS required CMDP to submit, at specified times during the contract year, the following BBA-related quality documents.

- Quality Management/Performance Improvement Plan, Work Plan, and Evaluation
- Utilization Management Plan, Work Plan, and Evaluation
- EPSDT and Dental Plan
- Maternity Care Plan
- Behavioral Health Plan
- Member Information (e.g., member handbook, newsletters)
- Performance Improvement Proposals, Interim Report, and Final Report
- Quarterly Provider Network Affiliation Transmissions
- Provider Network Development and Management Plan
- Cultural Competency Plan
- Material changes in CMDP's provider network (as appropriate)

All of the above listed documents were submitted to the AHCCCS Division for Health Care Management, which was responsible for their review and approval. Except for member information, provider network affiliation transmissions, and material changes in provider network, all of the documents, which primarily described CMDP quality-related plans for the contract year, were required to be submitted within the first 45 days of CMDP's contract year.

C. Review of Analysis Methodology

1. Operational and Financial Review

As with the data and data collection methodology, the *CYE 2004 AHCCCS Operation and Financial Review Tool* served as the framework for the analysis methodology. It provided the basis for assessing CMDP's compliance with federal and state quality-related requirements. AHCCCS prepared a crosswalk between the BBA regulations and

the OFR tool, documenting that the tool included standards for measuring compliance for the majority of the BBA requirements. For those few missing requirements (e.g., notification to impacted members regarding termination of their PCP's contract, consistency of practice guidance application in other areas of plan operation, oversight of subcontractors), AHCCCS plans on adding new standards to the OFR tool for contract year 2005. By adding these standards next year, AHCCCS will ensure that a review of CMDP's compliance with all the requirements set forth in 42 CFR 438.204(g) has been conducted within a three-year period.

Based on the data gathered during the on-site review and any additional follow-up document review, the AHCCCS review team prepared a final report of its findings and recommendations. For each standard, the reviewers rated CMDP's compliance using a five point rating scale—full compliance, substantial compliance, partial compliance, non-compliance, and not applicable. This more expansive rating scale allowed for greater sensitivity to the potential levels of performance, especially in complex performance areas.[4] In addition to the ratings, the reviewers also described their findings, and if appropriate, provided comments and recommendations. For each standard, AHCCCS OFR procedures required reviewers to be able to substantiate all findings, comments, and recommendations with any supporting documentation or notes from the review to be retained by AHCCCS.

AHCCCS successfully took several actions to enhance consistency among the reviewers in terms of their analysis of compliance with the standards. This included the establishment of the following standards.

- Rating definitions. As part of the OFR tool, AHCCCS provided definitions for the five point rating scale. For most standards the rating was determined by the percentage of the findings that meet the standard. For example, to be in full compliance with a standard, CMDP had to be 90% to 100% compliant with the standard findings. If a different rating methodology was used for a standard, this was noted in the OFR tool. For example, for rating compliance with the encounter standards, a statistical methodology was used to determine whether compliance was full, partial, etc.
- Recommendation definitions. There were three types of recommendations that reviewers were allowed to make - "the health plan must…," "the health plan should…," and "the health plan should consider…". Definitions were included in the OFR tool for each of these three types of recommendations. For example, if the recommendation was that "the health plan should do …," this was a non-compliant area that must be corrected to be in compliance with the AHCCCS contract, but it was not critical to the daily operation of the health plan.

As a result of the OFR review, CMDP is required to develop a corrective action plan for each standard in which there was a recommendation that began with "the health plan must" or "the health plan should." A corrective action plan (CAP) was submitted to AHCCCS on April 8, 2005, for review and approval, in response to the findings in the draft OFR, submitted to CMDP in March, 2005. On April 13, 2005, AHCCCS finalized

the CY 04 OFR, and returned its findings to CMDP's Program Administrator. Subsequently, on April 27, 2005, AHCCCS returned CMDP's CAP with its comments, and requested that it be updated and re-submitted to AHCCCS by May 16, 2005. Although all of these documents were exchanged outside the scope of this EQRO Annual Review timeframe, it is notable that areas identified for improvement are already being addressed by the health plan. A full review and analysis of the CY 04 OFR findings and final CY 04 CAP will be included in next year's EQRO Annual Report.

2. Review of Health Plan-Related Documents

Appropriate experts within AHCCCS were responsible for reviewing the submitted CMDP documents to ensure that they were in compliance with AHCCCS requirements as set forth in the contract, regulation, and policy. Upon completing the review, AHCCCS either sent CMDP a written letter of approval or a letter indicating areas of concern and/or suggesting recommended changes to the documents. Under the latter circumstance, CMDP was required to address the identified issues accordingly by amending the document(s) or submitting corrective action plan(s) within specified timeframes.

D. Assessment of Strengths and Weakness

1. Operational and Financial Review

The OFR report for CMDP concluded that while CMDP was compliant in several program areas (e.g., behavioral health, maternal and child health), there were several areas in which CMDP needed to improve (e.g., member services, financial management). A copy of the executive summary from the CY 04 OFR is in the Appendix section of this report.

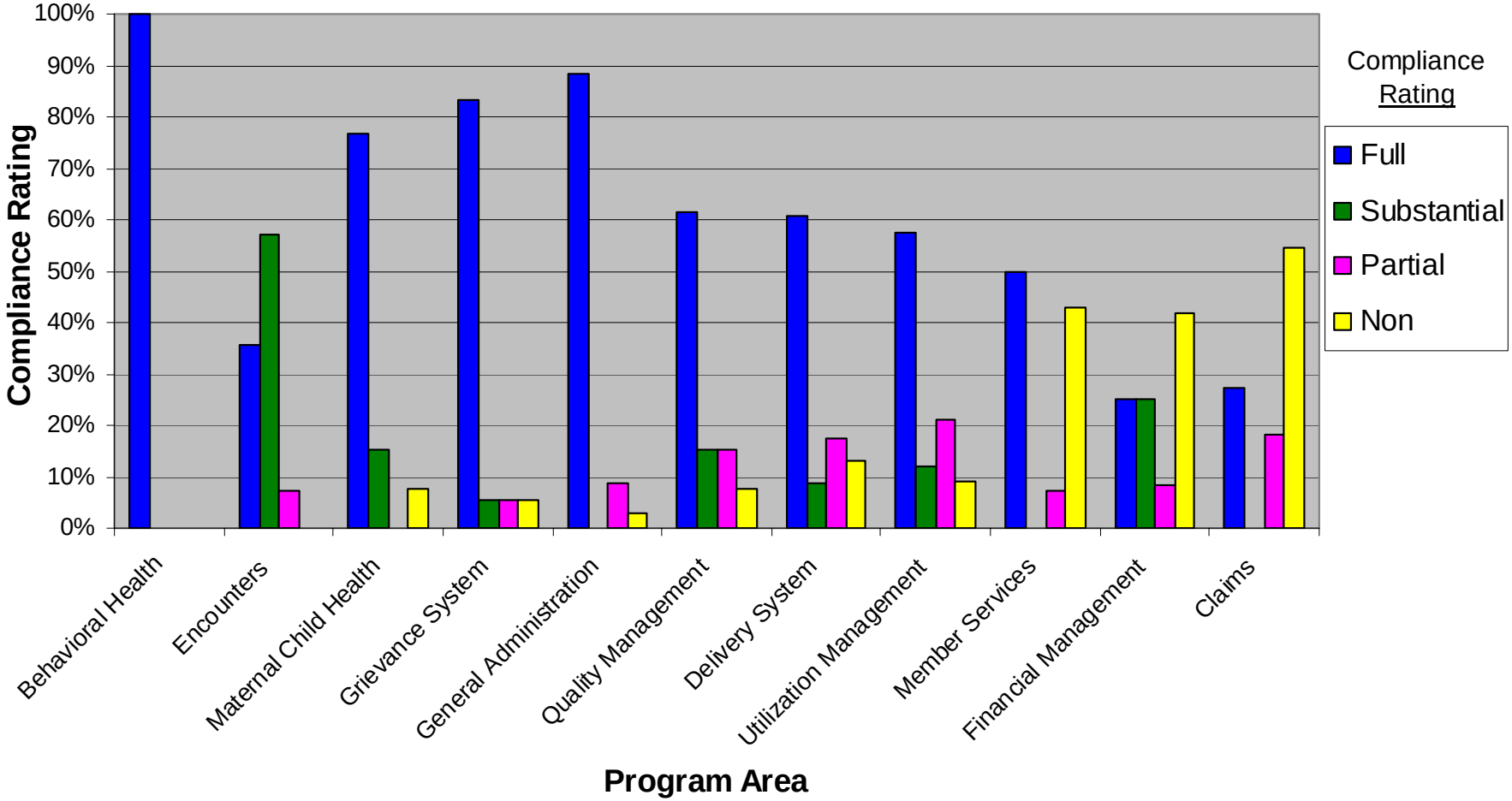
Program areas in which CMDP demonstrated the greatest strengths included Behavioral Health, Maternal Child Health, Grievance Systems, and General Administration, achieving full compliance on greater than 75% of the standards evaluated. Those areas in which CMDP demonstrated the highest percentage of noncompliance included Member Services, Financial Management, and Claims. Of the 191 standards reviewed, 42.9% required corrective action plans. Corrective action plans were subsequently submitted by CMDP, addressing all areas identified by AHCCCS as requiring improvement. A full review and comparison of the CY 04 OFR and CAP to the CY 05 OFR and CAP will be conducted in the CY 05 EQRO Annual Report.

Overall, CMDP was found to be in full compliance for 62.6% of the standards and was found to be non-compliant for 14.1% of the standards (refer to Table 8 and Figures 8 and 8.1). In addition, Table 8 and Figures 8 and 8.1 illustrate the percentage of standards in each program area that had a compliance rating of full, partial, substantial, or non-compliance. Table 9 and Figure 9 illustrate the number of standards that required corrective action plans in each program area.

Table 8: CMDP Operational and Financial Review Draft Results by Program Area for CY 2004*					
Program Areas	**Total Number of Standards**	**Compliance Rating for Standard**			
		Full	**Substantial**	**Partial**	**Non**
Behavioral Health	6	100.0%	0.0%	0.0%	0.0%
Encounters	14	35.7%	57.1%	7.1%	0.0%
Maternal Child Health	13	76.9%	15.4%	0.0%	7.7%
Grievance System	18	83.3%	5.6%	5.6%	5.6%
General Administration	34	88.2%	0.0%	8.8%	2.9%
Quality Management	13	61.5%	15.4%	15.4%	7.7%
Delivery System	23	60.9%	8.7%	17.4%	13.0%
Utilization Management	33	57.6%	12.1%	21.2%	9.1%
Member Services	14	50.0%	0.0%	7.1%	42.9%
Financial Management	12	25.0%	25.0%	8.3%	41.7%
Claims	11	27.3%	0.0%	18.2%	54.5%
Total	191	62.6%	11.5%	11.5%	14.1%

***** This table does not include standards which were for information only.

Figure 8: CMDP Operational and Financial Review Draft Results By Program Areas for CY 2004*



* This table does not include standards which were for information only.

Figure 8.1: Overall CMDP Compliance Results from the Draft CY 2004 Operational and Financial Review

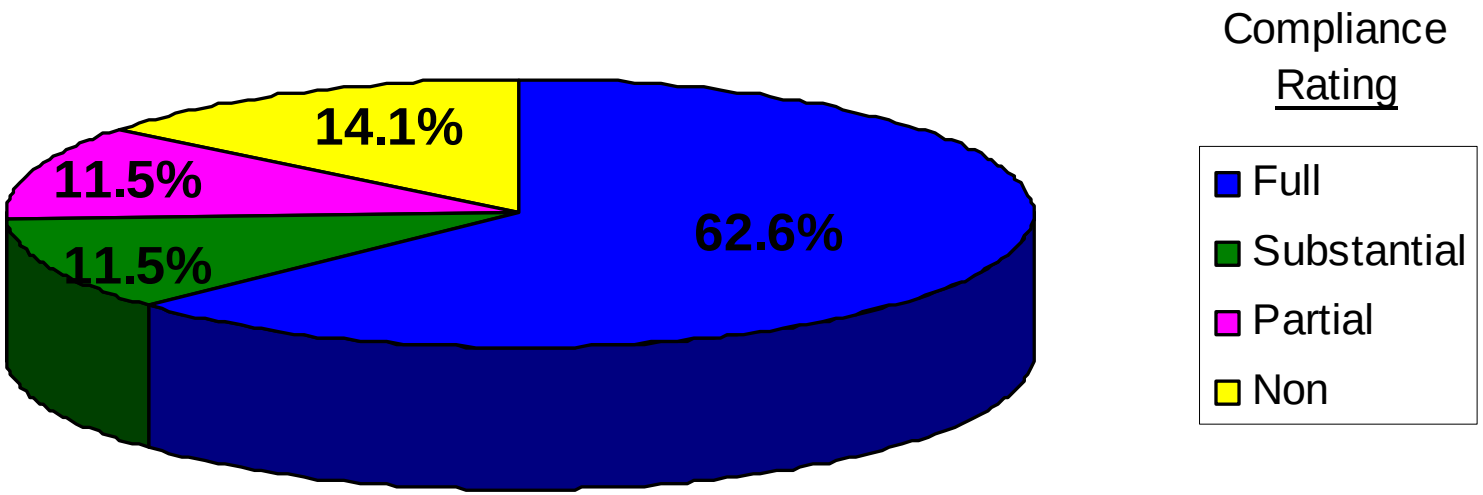
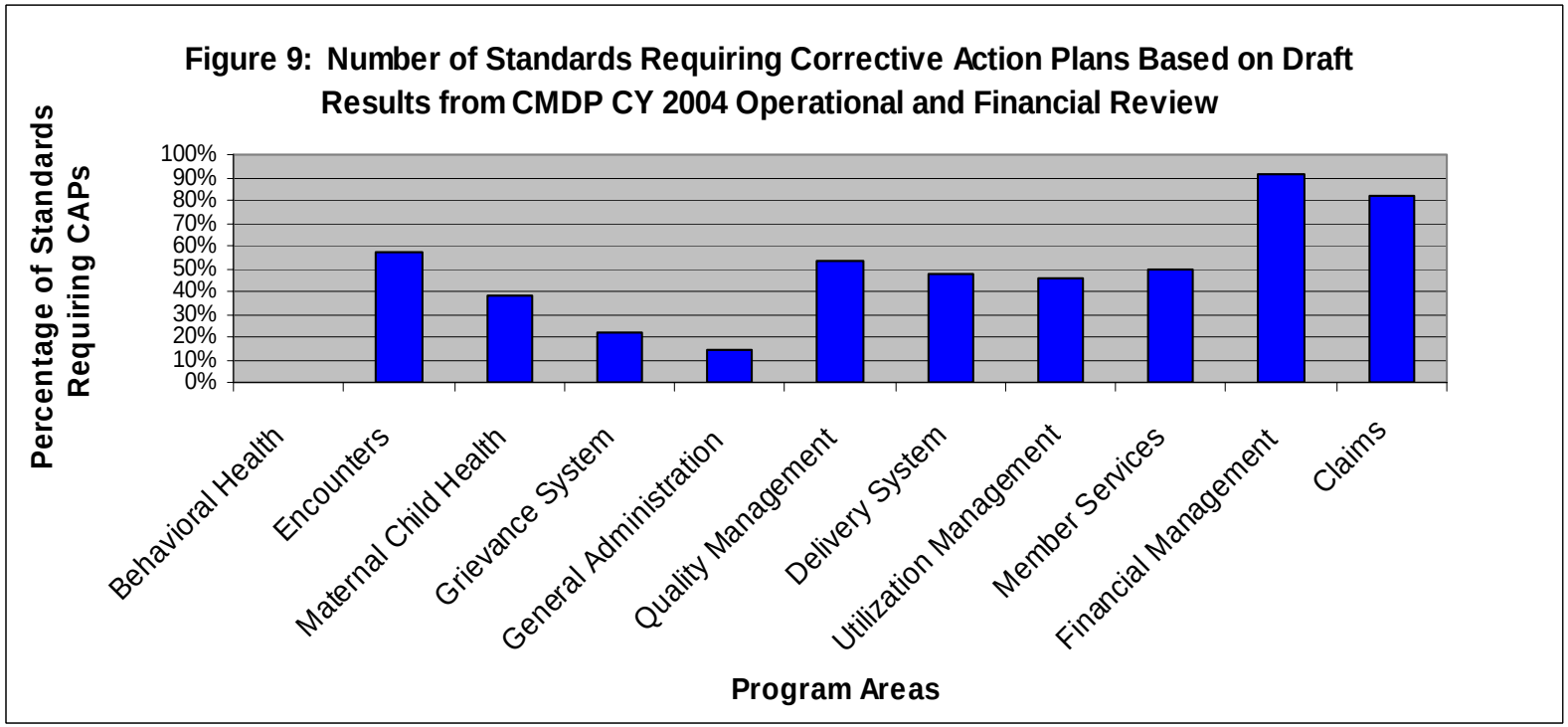


Table 9: Number of Standards Requiring Corrective Action Plans Based on Draft Results from CMDP 2004 Operational and Financial Review			
Program Areas	**Total Number of Standards**	**Number of Standards Requiring Corrective Action Plans**	**Percentage of Standards Requiring Corrective Action Plans**
Behavioral Health	6	0	0.0%
Encounters	14	8	57.1%
Maternal Child Health	13	5	38.5%
Grievance System	18	4	22.2%
General Administration	34	5	14.7%
Quality Management	13	7	53.8%
Delivery System	23	11	47.8%
Utilization Management	33	15	45.5%
Member Services	14	7	50.0%
Financial Management	12	11	91.7%
Claims	11	9	81.8%
Total	191	82	42.9%
Standards which were for information only but still required a corrective action plan are not included.			



2. Review of Health Plan-Related Documents

CMDP submitted all of the required health plan-related documents to AHCCCS. If necessary, these documents were amended and resubmitted for final approval by CMDP to AHCCCS. Timeliness of submission appeared to be an issue for a number of the documents (e.g., cultural competency plan, provider network plan).

E. Conclusions

AHCCCS has a well developed and comprehensive process for determining CMDP's compliance with federal and state regulations, involving both document review during the contract year, as well as an annual on-site operational and financial review of CMDP. The latter process, which involves document review, interviews, and observation, incorporates all seven of the compliance review activities included in the CMS protocol for determining compliance with Medicaid managed care regulations. The recently completed OFR of CMDP demonstrated the results of the plan's compliance with AHCCCS established standards to be acceptable, except for member services, financial management, and claims. AHCCCS will require CMDP to develop and institute corrective action for those standards in which AHCCCS made recommendations for plan improvement.

Notes

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 4000, 430 et al., Final Protocol, Version 1.0, February 11, 2003.

[2] Objectives were stated in the AHCCCS CYE 04 Operational and Financial Review Tool.

[3] Observation in the areas of member services, claims, delivery system, quality/utilization management, maternal child health was identified in AHCCCS OFR procedures (*AHCCCS Health Plan Operational and Financial Review).* However, no documentation was provided as to what type of observation AHCCCS performed during the CMDP review.

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 4000, 430 et al., Final Protocol, Version 1.0, February 11, 2003.

V. SUMMARY AND RECOMMENDATIONS

A. Summary

AHCCCS implemented quality assessment and performance improvement strategies that allowed it to assess the delivery of quality health care by CMDP and to require necessary interventions to remedy areas of deficiency, as required in 42 CFR 438.200. AHCCCS accomplished this through the following actions.

- Establishing and monitoring a defined set of performance measures against expected performance levels, as set forth in CMDP's contract with AHCCCS
- Designing and conducting, in accordance with CMS protocols, an AHCCCS mandated PIP to improve CMDP's immunization rates for two year old children
- Assessing CMDP's compliance with federal and state requirements annually through a document review and approval process, and an on-site operational and financial review, using a standardized tool and protocol
- Approving and monitoring the effectiveness of CMDP's corrective action plans to address deficiencies and improve performance

1. Performance Measures

For CY 04, AHCCCS required CMDP to participate in the following performance measures.

- Pediatric Immunizations (two-year old children)
- Children's Access to Primary Care Practitioners (ages 1 through 20 years)
- Dental Visits (ages 3 through 20 years)
- Well-Child Visits (ages birth through 15 months)
- Well-Child Visits (ages 3 through 6 years)
- Adolescent Well-Care Visits (ages 11 through 20 years)
- EPSDT participation

Table 1 and Figure 1 in Section II of this report, demonstrate CMDP's performance on the Children's Access to Primary Care Practitioners measure. The plan's performance in CY 02 was compared to its performance in CY 03, and to the performance standards determined by AHCCCS. There was a slight decline in CMDP's performance from CY 02 (83.7%) to CY 03 (79.1%). CMDP exceeded the minimum established performance standard of 77% in both years, and exceeded the AHCCCS statewide health plan average of 75.7% for CY 03.

As previously stated in section II, Review, Analysis, and Summary of Performance Measures, CMDP only met the AHCCCS minimum performance standards for two of the eight immunization measures, but continues to make progress toward improving its overall immunization rates. It also was noted that since the majority of CMDP members are removed from their home because of neglect, they often are on catch-up

immunization schedules. For seven of the eight immunization measures, CMDP's performance improved from CY 01 to CY 03, and for five of the eight measures, CMDP exceeded the national Medicaid plan average for CY 03.

For the Well-Child Visits measures, CMDP exceeded AHCCCS's minimum performance standard and the AHCCCS statewide health plan average for CY 02. For the dental visits performance measure, CMDP exceeded the AHCCCS minimum performance standard, the AHCCCS statewide health plan average, and the national Medicaid plan average for CY 02.

Overall, as stated previously, based on the mandated performance measure results for the measurement periods ending September 30, 2002 and 2003, CMDP appeared to be operating an effective service delivery system in terms of appropriate access and/or availability to and use of preventive health services.

2. Performance Improvement Project

For purposes of the EQRO Annual Report, AHCCCS requested a review of the state-mandated PIP on immunizations. Only preliminary results from the re-measurement study, published in March 2004, were available for this annual external quality review. The final re-measurement period for this PIP is expected to be released during the summer of 2005.

During the re-measurement period, CMDP demonstrated notable improvement in its immunization rates. CMDP now meets the AHCCCS minimum performance standard for four individual immunization rates, compared to only two during CY 03. Also notable is the fact that all of CMDP's 2004 rates are higher than the NCQA 2003 Medicaid HEDIS® health plan averages. Refer to Tables 6 and 7, and Figures 6 and 7, in section III, to illustrate the improvements made by CMDP compared to baseline measurements, AHCCCS performance standards, and national health plan averages.

3. Operational and Financial Review

Results from the operational and financial review (OFR) for CY 04 suggest that CMDP needs to continue to work on achieving full compliance with a number of the operational compliance standards. Based on the CY 04 corrective action plan submitted to AHCCCS in April, 2005, significant progress toward this goal is already being made.

B. Recommendations

While CMDP meets AHCCCS's minimum performance standards for access to Primary Care Practitioners, its performance had decreased. If the trend should continue, CMDP would not meet the AHCCCS minimum performance standards. AHCCCS has included language in CMDP's CY 05 contract that addresses situations where performance meets the minimum performance standard but begins to decline.

AHCCCS has a well developed process for monitoring CMDP's compliance with federal and state requirements related to the quality and timeliness of, and access to, care and services provided to members enrolled with CMDP. Given the operational and financial review results, it will be important that CMDP implement an effective corrective action plan to achieve and sustain compliance with the various standards, and improve its overall performance. AHCCCS should continue to provide technical assistance, as well as closely monitor the effectiveness of CMDP's proposed interventions.

Status reports, such as the quarterly EPSDT progress reports submitted by CMDP, should be enhanced as they relate to reporting on implementation and effectiveness of interventions for the AHCCCCS-mandated PIP.

While CMDP performed well, overall, on the state-mandated performance measures, emphasis should be placed on developing and implementing interventions aimed at improving their scores and sustaining that improvement.

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